Annex A

Self-Assessment/Accreditation Survey Tool for PhilHealth COVID 19 Home Isolation Benefit Package (CHIBP)

Name of Facility: _____

Address: _____

Contact Number: _____ **Email:** _____

Ownership of Health Facility: ○ Government ○ Private

Date of Assessment: (MM/DD/YY): _____

Type of Health Facilities:

☐ Hospital OPD Dept./Section (Level _____) ☐ Konsulta Provider

☐ Infirmary OPD Dept./Section

☐ CIU

PhilHealth Accreditation Number _____ **Accreditation Validity** _____

MINIMUM ACCREDITATION REQUIREMENTS	Applicant: Please check (√) the box corresponding to your answer		PhilHealth Surveyor: Please mark with check (√) if present (indicate evidence provided: photos, videos/ virtual observation), or mark with X if absent		REMARKS
	Yes	No	Yes	No	
1. DOH license (for hospitals and infirmaries) 2. Updated Signed performance commitment					
3. **Home Isolation Team** - employed or contracted by the facility 3.1. Certification of Employment/Contract Arrangement 3.2. Telephone number:_____ 3.3. Email address: _____ 4. Schedule of duties					
5. Physician: 5.1. Valid PRC License 5.2. Updated PhilHealth Accreditation 5.2.1. PhilHealth Accreditation Number_____ 6. Nurse 6.1. Valid PRC License					
7. General Infrastructure of Provider (Provide evidence: Photos, videos, virtual observation) 7.1. Dedicated room and IT equipment for daily operation 7.2. Functional Toilet (*for employees) 7.3. Fire safety provision					If any ONE of the items is missing, mark **NO**.
8. **Home isolation kit** (shall ensure availability once accreditation is granted) a. 1 liter 70% alcohol b. 5 pcs. Face mask c. 1 pulse oximeter d. 1 digital thermometer e. Drugs and medications (18 pcs. Paracetamol, 12 pcs. Lagundi tablets or equivalent, 6 sachets oral rehydration salts, 10 pcs Vitamin D and 10 pcs Vitamin C) f. Authorization and Consent to Participate in Teleconsultation					
9. **OTHER REQUIREMENTS**					
9.1. Referral Plan – Functional referral system from the community to higher level of health care facility, as applicable					
9.2. Service Delivery Agreement (MOA/Contract) with referral facility, as applicable					
9.3. Service Delivery Agreement with a qualified telemedicine provider (**optional**)					
9.4. Health facility has functional medical record (CIU and Konsulta providers only)					

Prepared by:

_____ _____

Head of Facility/ Medical Director/ Chief of Hospital
(Signature over printed name and date signed)

_____

(Designation)

Attested correct by:

_____